GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 30, 2026

Andre Lee
Lee Health Systems LLC
9611 Hazelton
Redford, MI 48239

RE: License #: AS820418207
Investigation #: 2026A0121015
Hazelton House

Dear Mr. Lee:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On 7/25/26, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (313) 456-0380.

Sincerely,

K. Robinson, MSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS820418207
Investigation #:	2026A0121015
Complaint Receipt Date:	05/06/2026
Investigation Initiation Date:	05/07/2026
Report Due Date:	07/05/2026
Licensee Name:	Lee Health Systems LLC
Licensee Address:	16519 Five Points Redford, MI 48239
Licensee Telephone #:	(586) 868-3718
Administrator:	Andre Lee
Licensee Designee:	Andre Lee
Name of Facility:	Hazelton House
Facility Address:	9611 Hazelton Redford, MI 48239
Facility Telephone #:	(313) 633-4558
Original Issuance Date:	01/06/2025
License **Status:**	REGULAR
Effective Date:	07/06/2025
Expiration Date:	07/05/2027
Capacity:	3
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
A resident was found unresponsive and later died with the incident occurring while a required 1:1 supervision plan had not yet been implemented.	No
Additional Findings	Yes

III. METHODOLOGY

05/06/2026	Special Investigation Intake 2026A0121015
05/06/2026	Referral - Recipient Rights
05/06/2026	APS Referral
05/07/2026	Special Investigation Initiated - Telephone Guardian A1
05/07/2026	Contact - Document Sent Email to Brian Harris with Detroit Wayne Integrated Health Network (DWIHN)
05/07/2026	Contact - Telephone call made Licensee, Andre Lee
05/07/2026	Contact - Telephone call received Email reply from Mr. Harris
05/08/2026	Contact - Telephone call received Mr. Harris
05/13/2026	Inspection Completed-BCAL Sub. Compliance Interviewed Resident B, Mr. Lee, home manager, Indya Moore, and direct care staff, Michelle Radford and Windell Pace
05/19/2026	Contact - Telephone call received Guardian A1

06/11/2026	Contact - Document Sent Follow up email to Brian Harris with DWIHN
06/23/2026	Contact - Telephone call made Kailan Mack with DWIHN
06/24/2026	Exit Conference Andre Lee

ALLEGATION: A resident was found unresponsive and later died with the incident occurring while a required 1:1 supervision plan had not yet been implemented.

INVESTIGATION: On 5/13/26, I completed an onsite inspection at the facility. I interviewed direct care staff, Michelle Radford and Windell Pace. Both Ms. Radford and Mr. Pace were the staff on duty when Resident A made his transition. Home manager, Indya Moore reported she was responsible for picking Resident A up from Corewell Health Wayne Hospital on 4/30/26. Ms. Moore explained that she made two trips to the hospital because at first Resident A seemed so heavily sedated that he could not consent to accompany staff. Upon her return to the hospital around 2:30PM, Ms. Moore stated Resident A agreed to be discharged to her care. According to Ms. Moore, hospital staff informed her that Resident A had been given Haldol as needed. Ms. Moore also reported Resident A could not stand or walk at the time of pickup. Per licensee designee, Andre Lee, Resident A could walk under normal circumstances. In fact, Mr. Lee stated that he was told Resident A had been combative and physically assaultive to the nursing staff at the hospital prior to his discharge. As a result, Mr. Lee advised staff that he would not administer any additional medication until Resident A became more alert. However, that never happened. Direct care staff, Michelle Radford reported Resident A slept most of his stay at the facility. Ms. Radford stated Resident A declined food or drink when offered. Direct care staff, Windell Pace came on shift to assist Ms. Radford at 10:00PM. Mr. Pace reported he completed bed checks with Ms. Radford every 2 hours. The following day, at approximately 7:15AM, Mr. Pace explained that Ms. Radford approached him to ask for assistance with Resident A, and that's when they found him lying unresponsive in bed. Ms. Radford said she immediately called 911. EMS arrived on the scene and pronounced Resident A dead upon arrival.

On 5/7/26 and 5/19/26, I interviewed Guardian A1. Guardian A1 appeared very emotional as she wept between sentences. Guardian A1 accused Corewell Health Wayne Hospital of gross negligence that contributed to Resident A's death. According to Guardian A1, Resident A was "fine" physically. Guardian A1 stated Resident A was admitted to the hospital for psychiatric treatment due to exhibiting aggressive behaviors at his previous group home placement. Guardian A1 absolved

Hazelton House staff of any wrongdoing as she declared, “I know it’s not their fault … it’s the hospital’s fault … he wasn’t at the group home for 24 hours!” Per Guardian A1, the family is currently awaiting the results of Resident A’s autopsy that are scheduled to return in 4-6 months.

On 6/23/26, I conferenced the case with Recipient Rights Investigator, Kailan Mack. Ms. Mack indicated that she will likely unsubstantiate the case as it appears whatever happened to Resident A may be connected to his hospital stay.

On 6/24/26, I completed an exit conference with Mr. Lee. Mr. Lee is adamant that he and his staff took appropriate action when caring for Resident A. Mr. Lee denied doing anything that contributed to Resident A’s unexpected death.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	There is no evidence that the licensee failed to provide supervision, protection, and personal care as specified in Resident A’s assessment plan considering Resident A was placed in the home less than 24 hours preceding his death.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 5/13/26, I observed Resident B using a wheelchair in the home. I interviewed Resident B. Resident B acknowledged that he does require the regular use of a wheelchair. Resident B stated that he was placed in the home on 3/18/26. Although Resident B has a walker too, he indicated that he only uses the walker to go to the bathroom. On 6/24/26, I completed an exit conference with Mr. Lee noting the additional finding. Mr. Lee reported that to date, Resident B remains in his care. Mr. Lee explained that he’s been working closely with the placing agency to locate a suitable placement for Resident B, but it’s been difficult because the resident requests to be placed in the least restrictive setting, preferably independent living. I advised Mr. Lee that there are significant risks imposed with Resident B’s placement in the home since it is not equipped to accommodate

individuals who require the regular use of a wheelchair. Mr. Lee stated he is committed to working with Detroit Wayne Integrated Health Network to discharge Resident B from the home.

APPLICABLE RULE	
R 400.725	**Means of egress.**
	(5) Facilities that accommodate residents who regularly require wheelchairs must be equipped with ramps located at 2 approved means of egress from the first floor. Ramps constructed before the effective date of these rules must not exceed 1 foot of rise in 12 feet of run. Ramps constructed on or after the effective date of these rules must comply with R 400.647(10). A ramp is not required when an egress door is level with the walkway.
ANALYSIS:	Mr. Lee failed to install ramps located at 2 approved means of egress from the first floor to accommodate residents who regularly require wheelchairs.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received; therefore, I recommend that the status of this license remains unchanged.

06/26/26

Kara Robinson Date
Licensing Consultant

Approved By:

06/30/26

Ardra Hunter Date
Area Manager